Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL HOUSTON
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Carrier's Austin Representative Box
#15

MFDR Date Received
APRIL 4, 2008

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-08-5060-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 25, 2008: "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)…Per the stop-loss method the carrier should have reimbursed the provider $158,007.19."

Requestor's Supplemental Position Summary Dated September 16, 2011: "1. **The carrier has already paid $102,571.39 for this admission; therefore it should be undisputed that the audited charges of $210,675.25 for [Claimant's] hospital inpatient admission exceeds the $40,000 stop-loss threshold**. 2. **The services rendered to [Claimant] were unusually costly and extensive**…because:

- [**Claimant] underwent multiple surgeries**. [Claimant's] hospital stay involved multiple surgical procedures on multiple days. On November 9, 2007, [Claimant] underwent the following procedures: (1) L4 osteotomy; (2) L5 osteotomy; (3) L4-L5 anterior discectomy; (4) L5-S1 anterior discectomy; (5) L4-L5 anterior arthrodesis with Infuse and Staylift prosthesis; (6) L5-S1 anterior arthrodesis with Infuse and Staylift prosthesis; and (7) Fluoroscopic supervision and interpretation greater than one hour. On November 12, 2007, additional procedures were performed on [Claimant]: (8) Posterior laminotomy, L4-L5 and L5-S1 – left; (9) Bilateral posterolateral arthrodesis with bone chips and Infuse; and (10) Segmental pedicle stabilization L4 through S1 – left.
- [**Claimant] suffered complications**. After his surgeries on November 9, 2007, [Claimant] required the transfusion of two units of blood postoperatively. On November 12, 2007, [Claimant] again required a postoperative blood transfusion…After his operations the hospital's cardiopulmonary services treated [Claimant] for hypoxia, bronchospasm, and also attempted to improve his alveolar ventilation.
- **The length of stay was outside of the ordinary**. When compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas, [Claimant's] seven (7) day hospital stay was outside of the ordinary because it was longer than most others and exceeded system norms…The average length of stay for hospital inpatient admissions system-wide in the State of Texas in 2007 was five (5) days. The average length of stay for 2007 admissions with Principle Diagnosis Code (722.10) and Principle Procedure Code (81.06) was three (3) days. [Claimant's] hospital stay was outside of the ordinary (unusual) because the length of stay, seven (7) days, exceeded the average length of stay for inpatient admissions system-wide in the State of Texas.
- **The cost of the admission as outside of the ordinary**. [Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded

the norm The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2007 was $39,766.32. The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (722.10) and Principal Procedure Code (81.06) in 2007 was $137,758.77. The charge for [Claimant's] admission was $210,675.25. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2007.

- **The costs were front-loaded**. The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment… For these reasons, the Medical Fee Dispute Officer should find that the second-prong of the two part test is satisfied and order additional reimbursement be paid by the carrier according to the stop-loss calculation methodology."

Amount in Dispute: $55,435.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 28, 2008: "Carrier has paid $102,571.39 and maintains this amount represents an over-payment under fair and reasonable guidelines."

Response Submitted by: Specialty Risk Services

Respondent's Supplemental Position Summary Dated November 17, 2011: "In short summary, an unremarkable hospital stay involving the exact services anticipated and nothing beyond routine post-operative care, by definition, does not trigger or qualify for reimbursement per the stop-loss exception. While the services provided were not unusually costly to the hospital, they were unusually priced to the carrier. This does not qualify the service for the stop-loss exception. The hospital has been overpaid under the applicable fee guideline. No additional payment is due."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
November 9, 2007 through November 16, 2007	Inpatient Hospital Services	$55,435.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – Workers comp state fee sched adjust. Submitted services were repriced in accordance with state per diem guidelines.
- W1 – WC state fee sched adjust. Submitted services are considered inclusive under the state per diem guidelines.
- W1 – Workers comp state fee schedule adjustment. Reduced to fair and reasonable in addition to the

normal per diem reimbursement according to rule 134.401 (C)(4)(B).

- W1 – WC state fee schedule adjustment. Services denied. No asc group associated with this procedure or not separately reimbursable to asc.
- W1 – WC state fee sched adjust. Reimburement according to the Texas medical fee guidelines.
- 45 – Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your HCN contract with FIRST HEALTH if you have any questions please visit WWW.FIRSTHEALTH.COM or call 800/937-6824.
- * – Paid in accordance with: FIRST HEALTH owned/accessed contract
- W4 – No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.

U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

Issues

1. Does the documentation submitted support that a contractual agreement exists in this dispute?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The insurance carrier reduced or denied disputed services with reason code "45." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $210,676.25. The Division concludes that the total audited charges exceed $40,000.
3. In its original position statement, the requestor asserts that "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)." 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." The requestor's original position statement failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services. In its supplemental position statement, the requestor considered the Courts' final judgment. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. The requestor's supplemental position statement asserts, that "The services rendered to [Claimant] were unusually costly and extensive…because: [Claimant] underwent multiple surgeries. [Claimant] suffered complications." The requestor's position that this admission is unusually extensive due to surgical procedures and complications fails to meet the requirements of §134.401(c)(2)(C) because the requestor failed to demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgeries or admissions.

   The requestor goes on to state:

   > The length of stay was outside of the ordinary. When compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas, [Claimant's] seven (7) day hospital stay was outside of the ordinary because it was longer than most others and exceeded system norms…The average length of stay for hospital inpatient admissions system-wide in the State of Texas in 2007 was five (5) days. The average length of stay for 2007 admissions with Principle Diagnosis Code (722.10) and Principle Procedure Code (81.06) was three (3) days. [Claimant's] hospital stay was outside of the ordinary (unusual) because the length of stay, seven (7) days, exceeded the average length of stay for inpatient admissions system-wide in the State of Texas.

   The Third Court of Appeals' November 13, 2008 opinion states that "…independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." A review of the data reports provided by the requestor finds that although length of stay for the services in dispute exceeded the average length of stay when compared to admissions with the same principal diagnosis and procedure code, the requestor did not demonstrate or explain how merely exceeding the average length of stay would: (1) constitute unusually extensive services; (2) categorize this case among the relatively few cases to which the stop-loss method may apply. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
4. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor in its supplemental position summary states:

   > [Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm… The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (716.16) and Principal Procedure Code (81.54) in 2006 was $49,117.27. The charge for [Claimant's] admission was $88,140.65. [Claimant's hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2006.

   The division notes that the audited charges of $162,438.50 are discussed above as a separate and distinct factor pursuant to 28 Texas Administrative Code §134.401(c)(6)(A)(i). The requestor asserts that because the amount ***billed charges*** exceeds the average for the same principal diagnosis and procedure codes, the ***cost***

of the services is therefore "out of the ordinary." Although the requestor lists and quantifies ***billing*** data, the requestor fails to list or quantify the ***costs*** associated with the disputed services. In the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276, the division concluded that "hospital charges are not a valid indicator of a hospital's costs of providing services."

The requestor further states:

> The costs were front-loaded**.** The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment.

The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the spinal surgery. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

The division concludes that the billed charges for the services do not represent the cost of providing those services. The requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was seven days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of seven days results in an allowable amount of $7,826.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $107,508.00. The medical documentation provided finds that although the requestor submitted purchase orders to support what the requestor was charged by the supplier for the implantables, there was no documentation found to support the amounts that the requestor paid for the implantables. The division finds that the cost to the hospital for the implantables billed under revenue code 278 cannot be established; therefore no reimbursement can be recommended for these items.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $2,743.75 for revenue code 382-Blood/Whole. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 382 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $351.90/unit for Thrombinar 5000 units. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $7,826.00. The respondent paid $102,571.39. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		3/22/2013
Signature	Medical Fee Dispute Resolution Officer	Date
		3/22/2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.